

Regionalization Workgroup

Discussion Paper - Meeting # 4

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The primary purposes of this discussion paper are to:

1. Facilitate further discussion of funds management (pooling) and governance from the previous meeting;
2. Provide additional information related to outcome and performance measurement as it relates to DHS's performance contract with regions;
3. Identify and discuss the pros and cons of issues related to the process for forming and sustaining county-based regions; and
4. Discussion of the potential interface between regions and Medicaid, particularly with regard to the home and community based waiver(s).

A. Funds Management

In the September 27th meeting there seemed to be consensus that county funds could be paid into a central unified account managed by the region (e.g., actual pooling), or they could maintain separate county-level accounts but agree to expend funds consistent with the regional management plan (e.g. virtual pooling).

Under an actual funds pool arrangement, counties would deposit funds into a central account, and the region would pay bills (primarily provide invoices) out of this account. Monthly or quarterly statements could be generated for each county regarding the expenditure of these funds: how much of each county's contribution had been expended, for what and for whom. Counties would be able to account for the use of county funds, but would not approve or write checks for payment. In the County Social Services Region model, counties view themselves as buying into a health insurance plan, not buying specific services for specific consumers.

Under a virtual pool arrangement, counties would actually pay for services rendered attributable to their county. The services provided would be defined by the regional plan; the provider billing for service would have to be in the region's network; and the service rendered would have to have been

approved¹ by the region. Under this scenario, providers (vendors) could theoretically receive payments from multiple counties for the same type of service but for different consumers based on county of residence. A variation on this approach could be to have the region maintain a central payment system, but then invoice counties for their residents after the providers are paid (this sounds like the current mechanism by which the state pays providers and then invoices counties for the non-federal share or MHI cost.)

One objective of the regionalization process has been described by Representative Schulte as “reducing transactional friction.” It would seem that actual rather than virtual pooling of county funds at the regional level meets the test of reducing transactional friction better than virtual pooling approaches. A regional pool of county funds does not have to be totally disconnected from county stewardship of its own funds. Rather, the pooled account could be envisioned as a “joint checking account”, from which county-by-county expenditures would be transparent and accountable to each county. Pooled funds could also be spent, with approval of the county-based regional governance board, for common or shared activities of the member counties. The most common example of these types of shared expenses will be for central regional administration and for regional support for shared services such as crisis intervention which are not wholly reimbursed through fee for service attributable to specific consumers.

B. Regional Governance

There was consensus in the Workgroup that regions should primarily have County Supervisor members or designees. If counties are to contribute funds to the regions, then they need to control the governing bodies of the regions. Three questions remain to be discussed related to county governance of regions. These are discussed briefly below.

- Should one or more consumer or family members be included on the governing body?

Consumer/family representation on regional or county level governing boards has become common throughout the United States. For the past 20 years Georgia has required greater than 50% consumer/family representation on their regional boards. North Carolina requires counties to designate consumers/families from each disability population (IDD, MH and substance use) to be members of multi-county regional boards. Ohio requires consumer family representation on both their single county and multi-county mental health and IDD boards. The national movement towards self advocacy, self direction, and recovery is predicated on consumers and

¹ This does not mean that every service has to be prior authorized: it just means that any service rendered would have to qualify for payment under the region’s plan – some services do not require prior authorization. Approval means that the consumer is a correct consumer for that service; the provider is an approved provider for that service; the service is provided within clinical guidelines or parameters established by the region; and that the rate paid for the service is approved or accepted by the region.

families saying “Nothing about me without me.” This is the primary reason why consumer/family representation on governing boards has become so common.

TAC identified two methods for including consumers/families on regional boards. One approach would be to have the county supervisors or designees constituting the regional board appoint some additional board members from among their consumer/family constituencies. Another model would be for each region to have a formal Consumer/Family Advisory Council, and allow that council to nominate some members to become full members of the regional board. Under either scenario, if a region had eight county members, with one Supervisor or designee from each county, it could establish an eleven-member governing body by including three consumer/family members.²

- Should one or more providers be included on the governing boards of the regions?

Providers are essential and valuable partners of regions and should be engaged and involved in all regional planning, service development, and quality management activities. From TAC and HSRI’s knowledge of other systems, provider councils or advisory groups are a key feature of virtually all state and county/regional MH and IDD system management structure. However, we are aware of no state or county/regional authorities that include providers as voting members of their governing bodies. Most jurisdictions have decided that the nature of the relationship between an authority and its providers is fundamentally different than its relationship with either member counties or with consumers and families. Regional authorities are both purchasers and authorizers of services; providers are sellers of services. For the benefit of both parties, most jurisdictions have decided to maintain a clear separation between the purchaser role and the provider role. This does not diminish the value of the partnership between providers and regional authorities, it only reflects and is respectful of the differences in their roles, responsibilities and imperatives.

- Should there be proportional representation or weighted voting under certain circumstances with respect to regional Boards?

The Regionalization Workgroup reached a general consensus that “one county – one vote” should be the general principle for the governing boards of regions. This reflects the understanding that all counties have equal stakes in the successful operations of regions, regardless of the size of their population and/or financial contributions. The Workgroup recognized that smaller counties with limited resources must be able to represent their consumer needs on an equitable basis, and also would need incentives (in the form of equity of governance arrangements) to participate with and not be overwhelmed by larger counties. At the same time, the Workgroup recognized that larger counties can benefit from full and

² Note: this is an example, not a firm recommendation.

collaborative participation of the smaller counties in a region, and that proportional or weighted voting could diminish the collaborative, all-for-one-one-for-all, relationships among the members of the regional consortiums. The primary purpose of regions is not to pit smaller counties against larger counties, but rather is to find ways in which they can work together most effectively and equitably.

However, it was noted that some circumstances might arise in which weighted or proportionate voting might be necessary or appropriate. Examples might include decisions with major financial consequences (e.g., addressing serious financial shortfalls), or major organizational issues (e.g., adding new members to a regional consortium).

TAC believes the Workgroup should discuss this issue again, to make sure a concrete recommendation can be forwarded to the Interim Committee.

One option would be to let the members of county consortiums forming regions to determine voting procedures of the governing body in their 28E agreement. There may be some natural solutions or local traditions of working together that would allow this issue to be addressed regionally. Under this scenario, the legislature would not have to establish formal mechanisms or criteria for proportional or weighted voting. Rather, it would only have to stipulate that Regions must address these issues in their 28E agreements.

Another scenario would be to recommend that the Legislature adopt some formal methods or criteria for voting in Regional Boards. For example, each county could by statute be granted a proportional vote equal to the percentage of people they contain or the percentage of funds they contribute to the region. Or, the Legislature could say that such proportional voting only pertains to specific decisions such as annual budget approval, applications for funding to the risk pool, or changes in regional consortium (and therefore governance) governance membership.

C. Performance indicators for Regions

At the last meeting there was insufficient time for a full discussion of performance Indicators and benchmarks for regions. Some members of the Workgroup and the audience agreed to submit examples of performance indicators now in use in the field. DHS has also made a list of its performance indicators available for review. These are posted on the website.

TAC also agreed to look at the performance domain table presented as part of the discussion paper for meeting # 3, and to be ready to discuss it further at meeting #4. The table, partially filled in, is inserted below:

Performance Domain	Yes	No	Examples for other States ³	Comments
Attainment of consumer and family outcomes	X		Employment; community living; children in families, children successful in school, quality of life	State-defined outcome domains and indicators reported and profiled at the regional level
Attainment of system performance outcomes	X		Reduced inpatient bed day utilization; reduced congregate care bed day utilization; family stability & re-unification; penetration rates; children served near their family	State-defined system performance measures reported and profiled at the regional level
Attainment of defined quality standards	X		Accreditation; credentialing; appeal and grievance frequencies and resolutions; critical incidents; workforce development; consumer/family satisfaction	Relate to CMS quality framework for waiver services
Ease of access to core services	X		Elapsed time from intake to first service; timely service connections following facility discharge; no gap in services for transition age youth	
Effective and consistent operations of TCM	X		Attainment of consumer outcomes; consumer choice and satisfaction with case manager	Must be monitored by DHS/IME, too

³ The Workgroups are developing recommended outcome and performance measures for Iowa. These are included just to provide examples of what types of performance indicators are typically included in these domains.

Performance Domain	Yes	No	Examples for other States ⁴	Comments
Provider network sufficiency	X		Adequate provider choice; cultural and linguistic competence; attainment of consumer outcomes	
Successful crisis prevention and diversion	X		Reduced crisis presentations at acute care sites; reduced inpatient hospitalization; reduced arrests; maintenance of community living (family and/or independent)	
Evidence of continuous quality improvement of all regional functions, including provider quality and effectiveness and workforce development	X		QM/QI reports documenting progress and results of QM/QI initiatives	
Timely and accurate payment of providers ⁵	X		Percent of clean claims paid within 30 days of submission; provision of accurate explanations of benefits to consumers (if requested) and providers	
Accurate funds management	X		Clean annual audit; less than 5% variation from annual budget; attainment of administrative cost limitations	

⁴ The Workgroups are developing recommended outcome and performance measures for Iowa. These are included just to provide examples of what types of performance indicators are typically included in these domains.

⁵ Including this domain does not assume that each region will physically adjudicate and pay claims – it only means that regions will be responsible to see that claims are paid in a timely manner and to correct problems if they exist.

Performance Domain	Yes	No	Examples for other States ⁶	Comments
Compliance with applicable state regulations and the performance contract between the state and the regions	X		Results of state monitoring and reporting of compliance with contract terms	
Timely and effective resolution of grievances and appeals	X		Meeting all timelines for appeals and grievances; low frequency of reversal of service authorization decisions on appeal; documented use of grievance and appeal data in QM/QI activities	
Other?				
Other?				

We will review this table during the Regionalization Workgroup meeting on Oct 11th. However, the review will only focus on domains for performance measurement, not actual measures, indicators, benchmarks and data sources. Those will be determined after the Legislature has acted on the major recommendations of the various Workgroups.

D. Discussion of the pathways to establish regions: what is the roadmap to get Iowa from county based systems to regional systems?

The Regionalization Workgroup has discussed and moved towards consensus recommendations on most of the functions and responsibilities of regions. The Workgroup has also heard from three groups of regions in Iowa, each of which has been working towards regional collaboration and “single plan” or co-management of certain county functions. The Workgroup has also heard from the Department on Aging, which is completing a legislatively mandated consolidation of Area Agencies on Aging (AAAs) into larger multi-county geographic areas. This process has been based on voluntary cooperation of the

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AAAs in planning their own consolidation and in defining new, larger, regions, but also has been driven by the underlying legislative mandate that must be met even if the AAA's chose not to cooperate in consolidation.

Several members of the Regionalization Workgroup expressed a desire to discuss a roadmap by which counties would achieve the formation of 10 to 12 regions with a range of population from 250,000 to 500,000, a minimum of three contiguous counties, and the presence of an inpatient unit plus either a mental health center or a FQHC will outpatient mental health services. Implicit in this discussion is the realization that not all counties have the same desire to participate, and not all have the same ideas about who will be their most desirable partners.

Most of the discussion, including input from Legislators, has been based on an implicit assumption that regions will form naturally and voluntarily. While this may be the most typical case, there is a need to formulate recommendation related to what will happen when natural and voluntary region formation does not result in the above criteria being met. These same recommendations should address what will happen, if anything, if one or more counties decide to leave a region, and/or a given region ceases to meet state performance standards.

In most jurisdictions, there is a balance struck between voluntary consortiums and the "right of free association" and the need of the state to see that every citizen, regardless of their county of residence, has equitable access to the system of services and supports managed by and access through the regions. Some state use a "right of first refusal" principle, in which they allow voluntary consortiums to form, but reserve the right to select some other entity to carry out defined regional functions if one or more of the local groups either chooses not to participate or fails to meet standards. Other states use a "balance of state" approach, in which the applicable state agency will function as the region for any part of the state in which regions have not been successfully formed. In North Carolina, the state has been shepherding smaller single and multi-county groups to merge into larger regions for over 15 years. This year, the state got tired of waiting, and said they would assign counties to larger regional entities if they did not voluntarily join together to meet state minimum population standards by 2013.

The following table summarizes the pros and cons of various approaches to the above issues that could be adopted by Iowa.

Regional formation strategy/issue	Pros	Cons
Should Counties be allowed to form regions voluntarily?	<p>Most likely to succeed if all parties are willing to participate.</p> <p>Most likely to be sustained through mutual problem solving because of the initial voluntary commitment to formation of the region.</p> <p>Most likely to move towards true regional integrated systems and consolidated funds management because of trust and the voluntary nature of the association.</p>	<p>Could take too long</p> <p>Not every county will want to join the nearest or most geographically contiguous regional group</p> <p>Some counties may not wish to participate at all</p> <p>Greatest amount of uncertainty about the outcomes of the regionalization process</p>
Should DHS have the authority to assign “orphan” counties to a region	<p>This is the only way to assure that all citizens of all counties will be included in regions.</p> <p>“Threat” of assignment could motivate movement towards voluntary participation.</p> <p>DHS and Legislature need to have a clear option to exercise if regional implementation falls behind schedule.</p>	<p>Could be viewed as contradicting the values of voluntary association.</p> <p>Could conflict with home rule.</p>
Should DHS have the authority to act on behalf of the citizens of a county if it chooses not to participate at all?	Same as above	Same as above
Should DHS have the authority to waive regional criteria if a naturally-formed regional consortium can document the benefits of such waiver(s)?	<p>This could provide some flexibility to support voluntary consortiums that almost but don’t quite meet all criteria (assuming that approval of a waiver would not negatively affect adjacent regions)</p> <p>DHS will need authority to assure that rigid application of criteria does not inadvertently cause harm to high quality existing service systems, relationship, etc.</p>	<p>Apparent willingness to be flexible could give counties incentives to prolong the process or to seek special waivers as a first choice rather than a last recourse.</p>

Regional formation strategy/issue	Pros	Cons
Should all regions be officially formed by the end of FY 2013?	<p>Extended time frames could hinder implementation of all other elements of the system re-design and reform.</p> <p>Phased or delayed implementation could disrupt planning and budgeting processes, particularly as major statewide changes in funding approaches are conditioned on regional formation.</p> <p>Setting the implementation date at the beginning of FY 2014 dovetails with expected changes in Medicaid under the ACA to begin in 2014.</p>	<p>A longer time frame could allow for a more organic and voluntary process</p> <p>Full readiness to function as a region is not the same as signing a 28E agreement. Some regions may not be fully up and running in time to “flip the switch” at the beginning of FY 2014.</p>
Should DHS have the authority to re-assign a county to a different region for the purposes of equity, quality of services, or problem resolution? What if a Region decides to dissolve?	<p>This is the only way to assure that all citizens of all counties will be included in regions.</p> <p>DHS and Legislature need to have a clear option to exercise if a region need to be re-formed or reconstituted in some way.</p>	<p>Could be viewed as contradicting the values of voluntary association.</p> <p>Could conflict with home rule.</p>
Should DHS have the authority to put a region into receivership it fails to meet DHS performance standards?	Same as above.	Could conflict with home rule
Should DHS have the authority to require inclusion of certain elements of 28E agreements or to approve 28E agreements used by regions?	<p>The statute now defines 28E agreements. SF 525 anticipates recommendations to the interim committee related to changes to 28E to support these regions. DHS should have the discretion to judge whether a given region’s 28E agreement meets the standards of the statute.</p>	<p>Within the general confines of the statute, the counties participating in a given region should have the discretion to decide what terms and operational provisions will be included in their 28E agreements.</p>

Regional formation strategy/issue	Pros	Cons
Should DHS use a RFP or RFI process to pre-qualify regions for a performance contract, or should a “readiness review” process be adopted?	<p>RFP/RFI process is rigorous, transparent and objective – commonly used to select managed care entities.</p> <p>Readiness review process is more conducive to the voluntary nature of regional formation and the understanding the regions will not have all functions and capacities up to speed on day one.</p>	<p>RFP process could take too long.</p> <p>Regions aren’t managed care entities, and they are not intended to be.</p> <p>Some regions could be ahead, and some could be behind, in the process of meeting all DHS standards for regional performance contracts.</p>

E. Topics included in 28E agreements

Interlocal agreements or MOUs typically include the following topics:⁷

- Purpose: what are the goals and objectives of entering into the interlocal agreement?
- Lead entity: who will be the host agency/entity to be the single point of accountability and communication with the state contracting authority?
- Parties to the agreement: which counties are participating in this particular interlocal agreement
- Term: how long is the agreement to be in force, and on what time frames will it need to be renewed? (For example, if there are sunset provisions in the statute, will the interlocal agreement sunset at the same time?)
- Methods for adding new participants: on what basis and under what circumstances will the initial partners admit one or more addition counties to the agreement?
- Governing Board: Membership; terms; methods of appointment; voting procedures, etc.
- Formation and use of consumer/family and provider advisory councils
- Executive function: role of the governing Board in appointing and evaluating the performance of the chief executive of the region; specification of functions and responsibilities of the executive
- Specification of functions to be (a) carried out by the lead entity; (b) the other partners in the agreement; and (c) via sub-contract with external parties (does not include provider network contracts)
- Methods for funds pooling, management and expenditure
- Methods for allocating administrative funds and resources

⁷ This list is generally consistent with Iowa’s 28E statute and with the 28E agreement currently used by the County Social Services Region.

- Contributions and uses of any start-up funds or related contributions made to the region by the participating counties
- Methods for acquiring and/or disposing of property
- Process for deciding on the use of savings for reinvestment
- Process for annual independent audit
- Method(s) for dispute resolution
- Method(s) for termination of the interlocal agreement and /or for termination of the membership of one or more counties in the agreement.

F. Discussion of the roles of regions in the management of Medicaid Home and Community Based Services

One issue for the roles and functions of regions is participation in the interface with Medicaid programs. Many individuals served under the regions and their designated TCM providers will be on Medicaid, and some people on Medicaid will also be receiving non-Medicaid services under the auspices of the regions.

A discussion of this interface can be informed by consideration of the current HCBS program. Currently there is a statewide set of HCBS slots (not allocated to regions or counties) and there is a statewide waiting list for HCBS services. Under the provisions of SF 525, in the future Counties (and therefore regions) will no longer be paying match for HCBS services. Finally, the federal CMS has become very clear with states that their HCBS programs must be state managed, RLS consistent and equitable statewide.

Thus, it will be beneficial for the regionalization Workgroup to discuss and consider recommendations related to how regions can effectively participate in and add value to the citizens, providers and state agencies (DHS/IME) participating in the HCBS program.

The following are some elements to be considered:

- Consistence of TCM/supports coordination
- Regional role in the use/oversight of SIS assessment and resource allotment process
- Potential role of regions in facilitating consumer self-direction under this or future waivers
- Potential regional role in reviewing and approving individual participant person centered plans
- Potential regional quality assurance/quality management activities and initiatives in compliance with CMS quality standards and process
- Potential interaction with DHS/IME related to HCBS waiver accountability and performance